SATURDAY, APRIL 19, 1873.

ORIGINAL LECTURES.

LECTURES
ON THE SURGERY OF THE NARES, LARYNX, AND TRACHEA.

BEING THE MÜTTER LECTURES FOR 1872.

Delivered before the College of Physicians of Philadelphia,

BY J. SOLIS COHEN, M.D.

Reported by R. M. BERTOLET, M.D.

(Continued from page 436.)

LECTURE VIII.

STENOSIS OF THE LARYNX AND TRACHEA.

STENOSIS, or stricture, of the larynx or trachea occurs in the wake of inflammation, whether traumatic, idiopathic, or specific. It follows chondritis and perichondritis with discharge of the cartilage. It may be due to organization of effused products of inflammation, or to cicatricial constriction following the healing of inflammatory ulcers, or to loss of tissue from injury. It is most frequently met with in connection with syphilis, but occurs in tuberculosis also.

The symptoms of this condition are those of impaired freedom of respiration; and on laryngoscopic examination we recognize alterations of parts, or adhesions of parts, diminishing the calibre of the tube. Sometimes the vocal cords are adherent in more or less of their extent; sometimes the ventricular bands are adherent in the same manner; and sometimes the inner surfaces of the arytænoid and supra-arytænoid cartilages are adherent. Tracheal stenosis is usually the result of vicious cicatrization of ulcers. It cannot always be recognized on laryngoscopic inspection, but is rather inferred from previous history, existing symptoms, and want of evidence of stenosis of the larynx, or external compression of the trachea. Sometimes the condition can be determined physically by exploration with bougies. This condition is a very serious one; necessitating, as a rule, the performance of tracheotomy and the permanent use of the canula. If the stenosis exists low down in the trachea, below a point at which a tracheotomy-tube can be inserted, there is no reliable remedy, inasmuch as stricture of the trachea is hardly ever susceptible of dilatation. In some cases of this kind it has been suggested that a long tube might be introduced low down through an external opening, and the maintenance of respiration be secured in this way.

Attempts have been made to dilate the calibre of the larynx and trachea by means of metallic bougies; and with a certain amount of success in some instances, respiration being secured by means of the tracheotomy-tube. Since the use of the laryngoscope, various operations have been performed, previous to the dilatation, for the purpose of relieving adhesions or removing exuberant tissue, the knife or the galvano-cautery being employed for the purpose. After such operation, dilating forceps are introduced through the mouth, and the parts kept asunder for a few moments and stretched. Then the dilators are introduced several times a day. In some instances the dilating tubes have been allowed to remain for several hours, or for several days; but there is great difficulty in their use, on account of the trickling of saliva down their sides into the larynx. Trendelenburg has tried to obviate this difficulty by inserting small segments of dilators, secured by a strong ligature which is allowed to pass out of the mouth. The string is less liable to excite salivation, and a smaller quantity gains entrance into the larynx. The treatment is exceedingly tedious. When the constriction seems in part overcome, a tracheotomy-tube with a valve or ball in it may be used, instead of the simple canula. This is for the purpose of encouraging expiration through the mouth instead of through the tube. If this goes on well, the tube is closed after a while, and both inspiration and expiration effected through the mouth. If this, too, goes on well, the tube is withdrawn for a few minutes every few hours, and, after a while, for a few hours every day, until it is evident that respiration can be effectually carried on in the natural manner; when the tube is finally withdrawn. It often happens that respiration becomes impeded in a few days after the withdrawal of the tube, so that the old incisions have to be reopened, and the tube employed again; but in a few days more it may again be withdrawn, and perhaps permanently. All this time dilatation with bougies is carried on daily by the patient, who should be taught the manœuvre, which should be persisted in for a long time.

It is useless to employ dilatation if the constrictions or the adhesions have not been previously relieved by the knife or cautery; for the parts are elastic, and, though they may stretch on the introduction of a bougie, they immediately come together again on its withdrawal.

Where it is impossible to overcome the stenosis by the means indicated, it would be questionable, in cases where the voice is irrevocably lost, whether, under suitable circumstances, an operation would not be justifiable, having for object the clearance of the larynx for respiratory purposes only. It seems possible that the larynx could be divided externally, the mucous membrane raised, the offending structures stripped off down to the perichondrium, and the mucous membrane then replaced. If the constriction concerned the upper portion of the larynx only, access might be had to it from the side, by Malgaigne's operation of sub-hyoid pharyngotomy.

ASPHYXIA.

Asphyxia—suspension or interruption of the access of air to the lungs, stoppage of the respiration—sometimes demands the services of the surgeon. Asphyxia may be caused by inflammatory swelling; organic obstruction; cicatrization; direct violence, accidental or surgical; closure of mouth and nostrils; hanging and choking; foreign bodies in the larynx, trachea, pharynx, or œsophagus; in-

halation of noxious gases; spasm of the larynx, from whatever cause; impaction of the epiglottis; the entrance of water, blood, or other liquids.

The various methods of restoring animation and keeping up artificial respiration are too well known to call for repetition in this report. They were briefly demonstrated by the lecturer, who stated that in the only instance in which he had an opportunity to try Professor Richardson's method of artificial respiration by means of a special bellows arrangement, which he exhibited and explained, he found it insufficient for the purpose, and abandoned it for Sylvester's method, by which he eventually saved his patient. The importance of immediate tracheotomy in case of impending death—even in cases of foreign body in the pharynx—was dwelt upon, and various devices were mentioned for maintaining the patency of the wound without the use of the tube, until the cause of the asphyxia could be removed.

FISTULÆ OF THE LARYNX AND TRACHEA.

A fistula of the larynx or trachea is either congenital, or the result of an abscess, or traumatic injury. Very little annoyance usually exists in connection with this affection, other than that arising from the more or less constant presence of discharge. The existence of an internal opening communicating with the air-tube can occasionally be seen with the laryngoscope, or is detected by the injection of some colored liquid, or by the passage of a fine probe along the fistulous tract. The egress of air from the interior at once denotes that the fistula is complete, *i.e.* has an external and internal opening.

The site of the external or cutaneous opening of congenital fistula of the neck is nearly always constant in the region of the sterno-clavicular articulation at the inner or outer margin of the sterno-mastoid muscle. Congenital fistula of the larynx is sometimes double-sided: out of forty-six cases reported by Heusinger,* ten were found to exist upon both sides of the neck. A fistula of the œsophagus or pharynx, or one merely leading to the thyro-hyoid bursa, must not be mistaken for an incomplete fistula of the air-passages.

The deformity in the neck, the constant presence of the discharge, and the frequent imperfections of the voice, often render the patient desirous of undergoing an operation for obliteration of the fistula, or at least of its cutaneous opening; but, as a rule, it is less successful than similar operations undertaken for the obliteration of fistulæ of inflammatory or traumatic origin in other parts of the body.

Several different procedures may be resorted to for obliteration of the fistula of the neck, the choice being determined by the size of the fistula. I. Simple suture may be used when the opening is small, with its borders covered by integument, and the edges drawn inwards. Dieffenbach† recommends that some inflammation be first set up in the edges by touching them with tincture of cantharides, before they are drawn together by sutures.

II. Twisted suture. This is employed when the opening is large enough to permit a view into the trachea. The edges are freshened by cutting out a small wedge of the cutaneous border, above and below; the borders are drawn forward with a hook and detached with a flat-bladed knife so far that they can be brought together from either side without any tension.

III. When there is great loss of substance in the trachea, it is covered with integument from the side of the opening. If the opening is a round one, the wound in the integument is made twice as long. The integument is loosened to the breadth of one inch on either side. The edges are confined by a row of twisted sutures. Then a straight vertical incision one inch and a half long is made in the skin on each side of the suture, at a distance of about three-quarters of an inch, which relieves the tension at once. The side-cuts are filled with charpie. In five or six days the needles are removed and adhesive plaster applied.

IV. When the opening in the trachea is large and the surrounding integument thin, the above procedure will not answer, as the thin borders of the wound afford too few points of contact. An elliptical excision is made, and the edges loosened, and then brought into perfect contact by several suture-pins. An incision two inches long is next made to either side, and the bridge of skin is still further and more thoroughly loosened. Both bridges are then pressed together by their subcutaneous surfaces; on either side a longitudinal cylindrical splint of stiff leather is placed, and two large pins are carried through these and the intervening bridges of skin. The double layer of skin is turned over so as to form a vertical wall to the opening. The splints are not removed until the borders are firmly adherent to each other.

V. Another operation is the transplanting of a flap. Velpeau‡ relates an interesting case of forming a flap and turning it over. This method is best performed, according to Basseran,§ by raising a flap of skin 1″ broad and 2″ long below the fistula, a little smaller above than below, and of sufficient length to readily reach the opening which it is intended to close. The flap should be dissected up with as much connective tissue as possible with it, but without laying bare the cartilages. The flap may then be placed in position in two ways.

1. When the greater diameter of the fistula is horizontal. The flap is folded together so that its tip does not quite reach its root, the cutaneous surfaces being in contact. It is better to unite the tip of the flap to its root by a simple suture. The flap is then turned upwards, but not rolled round, and thus fills up the fistula. In this way the raw surface of the flap is in part directed towards the cavity of the larynx, and in part forms the an-

* *Virchow's Archiv*, Bd. 33, S. 177.
† Die Operative Chirurgie, Bd. 1, S. 503.

‡ Mémoire sur les Fistules du Larynx; and Colombat de l'Isère, 1834.
§ *Journ. Hebdom.*, t. xxxii., xxxiii., 1834, and Schmidt's Jahrb., Bd. 5, S. 207.

terior wall of closure. A long needle is now thrust through the raw edges of the fistula and through the entire thickness of the flap. It must go through the posterior portion of the flap, and not merely between its two opposing surfaces. The flap then lies in the cavity of the larynx. The dressing is completed with ordinary sutures, adhesive strips, and bandage.

2. When the fistula is round, or its longest diameter vertical. Then the flap is rolled together in its entire length, so as to form a plug or cylinder, twisted, and its free end shoved a certain depth into the fistulous opening, no free space being allowed to remain between the raw surfaces.

M. Roux* has successfully pursued a new method. A catheter of a calibre equal to that of the inner fistula is inserted, and the integument brought around it by sutures; union by first intention generally follows, and later the internal laryngeal opening closes up by granulations, to which the presence of the obturator gives rise.

ARTIFICIAL OPENINGS INTO THE LARYNX AND TRACHEA.

A necessity for making an artificial opening into the larynx or trachea arises under the several circumstances which impede the free ingress of air to the larynx, and in which it is possible to remove the obstruction by operation through the opening, or to make an inlet for the air below the obstruction.

In acute cases, and where the opening is to be maintained for a comparatively short time, the operation usually performed, especially in the adult, is that known as laryngotomy, and consists essentially in dividing the crico-thyroid membrane. The cases suitable for this operation comprise acute laryngitis, œdema of the larynx, fracture of the larynx, the maintenance of respiration during the removal of a large or vascular neoplasm by laryngoscopic manipulation, and the extraction of small foreign bodies in the larynx.

The operation is usually an easy one, except in certain traumatic cases, or other cases in which there is a good deal of emphysema. The position of the crico-thyroid membrane is determined by the touch, the patient being either recumbent or semi-recumbent, and the parts rendered prominent by elevation of the shoulders; and a vertical incision from an inch to an inch and a half in length is made in the middle line, so that the middle third comprises the position of the ligament. The ligament is then freed of any overlying tissue not divided in the vertical incision, care being taken not to divide the middle thyroid artery, which may be in the way of the knife, and which is to be held to one side, or otherwise secured, as the case may be. The ligament is then divided vertically, or horizontally, or crosswise, according to the nature of the case. When the opening thus made is insufficient for the purpose required, the incision is carried upwards, so as to divide the intermediate plate of the thyroid cartilage to a certain extent; care being taken to avoid wounding the vocal cords.

In other cases the cricoid cartilage is divided; but it is well to spare this cartilage if possible.

Sometimes it becomes necessary to divide one or more rings of the trachea in order to render the opening large enough for the free play of instruments. Under these circumstances the operation is known as laryngo-tracheotomy.

Tracheotomy may be performed above the thyroid gland, or below it. It is well to avoid this structure whenever it is possible to do so. The operation may be expeditiously performed as follows: The patient being in position, and everything ready, the operator places himself at the right of the patient, and his assistant stands on the opposite side. The skin being made tense by the thumb and fingers, or pinched up into a transverse fold, at the option of the operator, a vertical incision is made, dividing the skin and fascia from the cricoid cartilage to within an inch or so of the sternum. The operator then raises the connective tissue on his side of the incision with the forceps, his assistant doing likewise on the other side, and the fascia is then divided, fold after fold. The veins should be held out of the way by blunt hooks, or, if this is impracticable, should be ligated in two places, and divided between the ligatures. The muscular structures are separated by the fingers and handle of the scalpel, until the trachea is exposed; the fascia being raised and divided in the manner described. The thyroid gland is held upwards or downwards by blunt hooks, according as the operator intends entering the trachea above or below it. If this cannot be done with safety, it is encompassed with two ligatures, between which it is then divided. Any large vessels crossing the thyroid must be ligated first, and then divided in the same manner. During the operation the field must be kept clear by sponging, and moderate hemorrhage restrained by small bits of ice enclosed in a cloth. When the trachea is cleared, and the place for incision is in view, the tube is drawn upwards and steadied by means of a tenaculum, and divided from below upwards as far as may be necessary, care being taken to penetrate the mucous membrane, and to avoid wounding the posterior wall of the trachea. Air rushes through the opening with a peculiar hissing noise, driving the blood and mucus before it. The edges of the opening are now seized with toothed forceps and separated, when the necessary hooks or tubes are introduced. These instruments should be warmed before their introduction.

The abnormal course of the blood-vessels sometimes divided in this operation may give rise to serious hemorrhage. This hemorrhage, even if venous, is by no means always restrained by opening the trachea, and thus permitting re-establishment of the normal circulation, although Trousseau and others have operated hundreds of times without ever being embarrassed in this way. It is therefore advisable, in all instances where delay is not evidently dangerous, to restrain the hemorrhage before opening the trachea. Occasionally the hem-

* *L'Union Médicale*, 1855, p. 129.

orrhage is insignificant, not requiring the slightest delay or the securing of any bleeding vessels. After respiration has become quiet, the necessary operation for which the opening into the trachea was made is proceeded with, or the tracheotomy-tube inserted, as the case may be. It will usually be found sufficient to separate the lips of the tracheal wound by means of a tenaculum introduced upon each side to guide the tube safely; though special dilators have been devised for this purpose.

The edges of the external wound are brought together by strips of adhesive plaster, except at the lowest portion, which is left patent for drainage. A piece of oiled lint is slit and slipped under the tracheotomy-tube, to prevent undue chafing, and the wound covered with a simple dressing. A piece of gauze is confined over the wound by adhesive strips, to protect it from dust and to modify the temperature of the inspired air.

As long as the patient is confined to his room, the temperature should be maintained at about 80° Fahr., and the air kept more or less saturated with steam, in order to lessen the risk of subsequent bronchitis.

A double tube should always be used, the inner tube being the longer. This inner tube requires more or less frequent removal, to free it from inspissated mucus, which adheres to it, at times, in sufficient quantities to impede respiration.

When the tube is permanently withdrawn, the opening usually closes in a few days without surgical assistance.

The lecturer spoke of the occasional performance of tracheotomy for the purpose of inserting a tube and occluding the trachea above and around it, so as to prevent the escape of blood down the trachea in the performance of operations in the mouth and larynx. He exhibited the apparatus devised by Trendelenburg for this purpose. It consists of a tracheotomy-tube which is encircled by a hollow cylinder of rubber, communicating with a tube provided with a stop-cock. Air being forced into this tube, the cylinder around the canula becomes distended into a complete obturator. There is also a special arrangement for administering anæsthetics through the canula. Trendelenburg and one or two other foreign surgeons had employed this apparatus with satisfaction; but the lecturer was unaware of any instances of its application in this country, and had had no personal experience with it.

The lecturer also referred to the production of emphysema after tracheotomy, a complication occasionally encountered, and of which sufficient mention is not made in the books; and he instanced a typical case of the kind still under his treatment, in which a marked emphysema had followed tracheotomy performed as low down as possible, a short time ago, for perichondritis of the arytænoids. On the day of the operation emphysema set in, and by night had extended down to the shoulders and as high as the zygomatic process, lifting the canula completely out of the trachea. An unusually long tube was substituted for the shorter one, and the emphysema began to decline the next day.

ORIGINAL COMMUNICATIONS.

STRABISMUS CONVERGENS:

WITH SPECIAL REFERENCE TO ITS ÆTIOLOGY.

A Paper read before the Northern Medical Association of Philadelphia.

BY S. D. RISLEY, M.D.

(Continued from p. 439.)

DONDERS, finding this almost universal association of hypermetropia with strabismus convergens, could not escape the conclusion that they sustained to each other the relation of cause and effect: "Hypermetropia is indeed the primary anomaly, to be sought for in the structure of the eye, and originally proper to the organ; strabismus is the secondary condition, which does not arise until some years after birth." That hypermetropia is the cause of the deviation finds strong corroborative evidence in those cases seen in the very commencement of the deformity, during the stage of so-called periodical strabismus; for in these the fact that hypermetropia already exists is presumptive evidence that it precedes the deviation, and the additional fact that the correction of the anomaly of refraction removes the tendency to squint seems to leave no room for doubt.

October 10, 1872.—Howard F., æt. 8 years, was brought to me by his parents, with the statement that when he looked at his book, or intently at distant objects, he became cross-eyed, but that when around at play his eyes were straight. The ocular movements were normal in all directions. $V = \frac{3}{4}$ in each eye (Snellen $\frac{15}{XX}$), and he could read No. 1 of Jaeger's test-types no nearer than 6″ to the eye, while had he enjoyed emmetropia he should have been able, at his age, to read it up to 3″ readily. His distant vision was brought up to normal by convex glass of 24″ focal distance. After atropization his vision fell to $\frac{1}{4}$, and the determination revealed total $H = \frac{1}{16}$. I prescribed convex glasses to be worn continually of 20″ focal length ($+\frac{1}{20}$), which more than corrected his manifest hypermetropia. Six weeks later his parents returned with him, that I might see the result of my advice, which had proved entirely satisfactory, as there had been no tendency to squint since the use of the glasses.

The deformity usually commences about the time the child begins to use its eyes for near objects,—*i.e.* from the fifth to the tenth year; although it occasionally occurs earlier than this. I wish to dwell upon this point, so that when the mother calls attention to the fact that her infant "squints" it may not be passed over as a fact of but little moment. The stronger probability is in favor of the deviation being due to ocular paralysis from some intra-cranial cause than of its being a case of simple strabismus.

At first it assumes a periodical character, as seen in the case of Howard F., appearing only when the patient is intently regarding some object,—it may be only when reading or looking at some near object. At this stage either eye is used indiscriminately, while the other moves inwards. If the hypermetropia be not neutralized by the constant use of suitable convex glasses, the squint will generally soon become permanent, presenting all the characters of concomitant strabismus.

Parents bring their children with all sorts of stories regarding the cause of the squint. In looking over my notes I find the following. One child, æt. 5 years, with permanent convergent squint of one year's standing, had fallen, striking the side of his head corresponding to the converging eye against the marble doorstep. The mother says he has squinted ever since. The child had H = $\frac{1}{48}$. Another never squinted until after an attack of measles. Ophthalmoscope shows H = $\frac{1}{36}$. Another with H = $\frac{1}{24}$ had learned to squint at school by imitating a little playfellow. He had H = $\frac{1}{48}$. Many insist upon it that the children were born so. One mother thought the squint was produced by the cradle being placed so that in looking after her, while about her household duties, the child must turn its eyes always in the same direction. A fragment of black court-plaster worn on the temple corresponding to the squinting eye, for the purpose of "drawing the eye back," had failed to effect a cure: so she came "to have them straightened." The child had H = $\frac{1}{36}$. There is some plausibility in its occurrence after an attack of either of the exanthemata, first admitting the existence of hypermetropia; for the accommodative power must participate in the general exhaustion following a fever, and thus the tendency to excessive convergence would be increased in proportion to the inability of the ciliary muscle to perform its accustomed task. The idea of imitation seems to have gained some credence even among physicians. I am not prepared to deny that strabismus is ever thus produced; but it is more probable that a common cause has produced it in both parties,—the imitated and the supposed imitator. Hypermetropia is very prevalent, and frequently hereditary. I have myself repeatedly seen several members of the same family hypermetropic. It is in such instances that we would expect to find more than one member with squint, a common cause inducing it. That such is the case I have had repeated opportunities for verifying.

How far the association of a non-squinting hypermetrope with one who squints may influence a tendency to deviation already existing, I am not prepared to say, but can readily conceive how it might determine a squint which, without such influence, might never have existed.

At the onset of the affection the shortening of the internal recti muscles seems purely dynamical; but later, after the deviation has become permanent, one eye being used invariably for fixing, it passes over into an organic change, hypertrophy resulting from the excessive task to which they are subjected, and the shortening becomes permanent; not of one but of both internal recti.

From this fact of organic shortening of both muscles we would be led, *a priori*, to anticipate but little from any treatment for its cure save from tenotomy, and that not of one but of both muscles. That both muscles—that of the undeviated as well as of the deviated eye—should be shortened, might be anticipated. In the first place, the hypermetropia can be best overcome by a strong convergence, on account of the increased power of accommodation thus afforded: moreover, in order to throw the image as far as possible from the macula lutea of the deviated eye, that, falling upon a more peripheral and less sensitive portion of the retina, it may the more readily be suppressed, the object is held to the side corresponding to the deviated eye. From these two circumstances the internal rectus muscle of the fixing eye is also kept in relatively strong contraction. By this effort, too, the degree of deviation of the squinting eye is relatively increased.

So long as the strabismus remains as alternating squint, the acuteness of vision is not lowered; but no sooner does the deviation become constant than the affected eye begins to suffer a diminution of vision, which rapidly becomes more and more marked. In a child between five and six years old who had begun to squint one year before, I found the acuteness of vision reduced to one-half. One month after tenotomy, however, the vision was normal in each eye.

This diminution may go on from a mere shade of difference between the eyes to an almost total loss of vision. There are some things about this loss of vision in the squinting eye which are somewhat contradictory. After the acuteness has become considerably diminished, it will be found difficult to induce the patient to fix an object with the deviated eye when the other is covered, or, when attempting to fix with it, he will be unable to recognize the largest type at any distance. He persistently refuses also to see double images even of a bright object, as a lighted candle. From these experiments one would be led to conclude that vision was entirely abrogated. That such is not the case, however, I am led to infer from the fact that we do not observe in such persons the peculiarities of one-sided vision. The man who has had one eye extirpated feels sadly the loss of the member, and complains that he must turn himself in order to see things on the side corresponding to the lost eye. He will tell you he never feels safe at the street-crossing, lest a team drive upon him unawares. Strabismic patients never make like complaints, however, and seek surgical aid for relief from the deformity alone. There is no discoverable organic change in the retina in these cases. That we can sharpen our senses by a strict mental attention is a fact of which we see constant proof, and that by a psychical exclusion we can also set aside physiological sensibility is well illustrated in these cases of strabismus. As in the case alluded to above, however, after the axis of the deviated eye has been forced by tenotomy to resume its parallelism, so that the image will once more fall upon the macula lutea, the acuteness of vision may be greatly improved, or, if the exclusion has not been of too long standing, may even regain its normal sharpness.

A case occurred to me which illustrates forcibly this point:

H. M., æt. 19, had had tenotomy performed on both sides in 1869 for the cure of strabismus. I saw her for the first time a year and a half later. She then had a permanent convergence of the left eye, measuring $3\frac{1}{2}'''$, and vision of $\frac{1}{6}$, while in the right or fixing eye there

was for distance a normal acuity of vision. The patient stated that for a few months after the operation the eyes remained "straight," and then the deformity rapidly returned, but changed sides, the opposite eye becoming the deviated one. At the time of the first operation the left or fixing eye was the good one, while she was "almost blind" in her right.

She had but little manifest hypermetropia ($H = \frac{1}{24}$), although, after thorough paralysis of the accommodation, a total hypermetropia of $\frac{1}{12}$ was revealed in each eye. Tenotomy on both sides was repeated, and positive glasses of $\frac{1}{12}$ given to be worn constantly, with instruction to exercise the left eye alone for an hour or two daily on the finest print that could be recognized. Three months later there was no return of the convergence, and the acuteness of vision had come up from $\frac{1}{10}$ to $\frac{3}{4}$.

In strong contrast to this is the case of an Irish girl, æt. 17, who consulted me in June, 1871, for marked convergence of the right eye which had lasted since early childhood. She came seeking relief from the deformity. She had $H = \frac{1}{10}$ in the deviated eye, and was only able to count fingers with difficulty at a few feet with a correcting glass. In the fixing eye there was normal acuity of vision, with the glass, which corrected the existing hypermetropia.

I performed tenotomy, which corrected the deviation; but a year later there was no improvement in the acuteness of vision in the formerly deviated eye. How faithfully she had obeyed my injunction to exercise the eye I cannot say. There was no longer any tendency to squint.

Strabismus should not be regarded as a mere deformity, and the operation for its relief as for a mere cosmetic effect. Permanent strabismus means, sooner or later, the more or less complete loss of vision in one eye; hence it is a condition demanding treatment as positively as an iritis or keratitis, and it should be thus represented to patients, who invariably regard it only as an unfortunate deformity.

The question naturally arises here, When should the operation be performed? I think the sooner after the development of permanent strabismus the better; for why should we wait until the sharpness of vision is diminished? There are other questions involved, however, which have caused some to hesitate, and even to advise the parents to have nothing done at present, but after a few years, when the child has gained in years and discretion, to return. It is true that after the operation the same cause is acting to reproduce the affection as was active at first in its production; and that there is a marked tendency to its recurrence we saw in the first part of this paper. The only way, in fact, to insure against the return of the deviation is to correct the optical defect which is so active in its ætiology, by prescribing proper glasses. Now, there is an obvious difficulty in the way of prescribing glasses for young children; yet in the case of Howard F., æt. eight years, with strabismus alternans, I did not hesitate to do so, rather than to allow the deviation to become permanent. In one case I operated at the fifth year. The deviation, although of but one year's duration, was fast becoming permanent, and already there was diminished sharpness in the deviated eye. The parents, however, were informed of the liability to the return of the deformity, and were carefully instructed to bring the child back if any tendency to relapse should at any time manifest itself. The acuteness of vision in the deviated eye might be preserved by persistent daily use of the deviated eye, compelled by keeping the opposite eye closed or by paralyzing its accommodation repeatedly by atropia. Binocular vision is so important that too much cannot be done to preserve the function of both eyes intact. I would not hesitate, then, to operate even earlier than the fifth year, if a case of permanent strabismus should present itself at so tender an age.

After what has been said of the cause of strabismus, the justice of my remarks regarding the claims to unvarying success made by some, and the rude denunciation of those who were sufficiently honest to acknowledge failures, I think will be no longer doubted. Hypermetropia was not yet understood; and that there should be no return of the deformity in a certain number of cases while the original cause still existed, I am scarcely willing to admit. That the deviation is frequently reproduced, we have abundant evidence in the experience of the earlier operators. I have also had frequent opportunities to observe the recurrence of the affection in cases operated upon in this city.

The case of H. M. is an illustration of this. Out of eight cases from a charitable institution in this city, operated upon at one sitting, no regard being paid to the optical condition, but one has proved at all satisfactory. In six cases, taken from my private practice, which I have been able to follow up for six months, for whom glasses were prescribed, in but one is there any tendency to a return. This patient was a lad of fourteen years, who, in consequence of the gibes of his schoolmates, persistently refused to wear his glasses. Six months later the deviation was as great as before the operation, which at first had been perfectly successful.

In cases of permanent convergence, the degree of hypermetropia should be carefully determined, with a view to correction by means of spectacles; afterwards, tenotomy of one or both internal recti. No new principle in the operation has been enunciated since the days of Stromeyer. Its details have been rendered less cumbersome, however, and experience has taught us how to regulate the extent of the operation.

The object to be attained is to cut the tendon of the muscle as near its insertion in the sclerotic as possible, and secure its re-attachment at a point farther back upon the globe,—the extent of the retraction to be controlled by the extent of laceration in the capsule of Tenon.

1438 North Thirteenth Street, Philadelphia.

COFFEE AND SULPHATE OF QUINIA.—M. Briquet considers the common practice of administering quinia in coffee open to much objection. He alleges that the tannin in the coffee coalesces with the quinia, forming a tasteless and insoluble and almost inert salt,—the tannate of quinia,—from which the stomach has as much difficulty in extracting quinia as from powdered bark. It is, he thinks, one of the worst preparations of quinia.

TWO CASES OF RETAINED FŒTUS SOME MONTHS AFTER THEIR DEATH,

AND TWO CASES IN WHICH PLACENTAS WERE RETAINED A GREAT LENGTH OF TIME AFTER THE EXPULSION OF THE FŒTUSES.

BY E. P. ALLEN, M.D.

IN the month of November, 1845, I was summoned to see Mrs. M. C., who was reported to have lock-jaw, or tetanus. I learned from her husband that she was thirty-five years of age, and the mother of four children, and had until two months since enjoyed comfortable health, though never very strong; that seven months before, she had become pregnant, without unusual symptoms until she had gone five months, when she felt unwell for a few days, and in a short time all motion of the child ceased. Her breasts became flaccid, and her abdomen subsided to its natural size. Her health became poor, and she consulted a physician, who told her that her child was probably dead, and she would be in labor soon, and get through without trouble, and then she would soon regain her health. Labor did not come on, and she steadily declined. Her jaws began to be stiff two days before, and steadily grew worse until that morning, when they became immovable. They could not be separated at all by any force safe to use; yet she had little pain, though an uncomfortable stiffness was felt. She was thin in flesh, and countenance pale and anxious; appetite poor, and bowels constipated. No one would have suspected from her appearance that she was pregnant of a seven months' child, or even of a five months' child. She was ordered to take an ounce of castor oil to unload the bowels, which she was able to suck through a cavity made by extracting a tooth some time before. The oil produced a copious evacuation in four or five hours, and was followed by labor-pains, which soon became regular, and she was delivered about two o'clock on the following morning of a fœtus apparently of about five months' growth, though greatly shrivelled and emaciated. The liquor amnii was quite dark-colored, but had little or no fœtor.

I have never been able to satisfy myself of the cause of the death of the fœtus.

The mother recovered slowly by the use of tonics and laxatives; though it was four weeks before she had the free use of her jaws. They were firmly closed ten days, when they gradually relaxed. She has since borne children.

I suppose the physiologist would assign the cause of the tetanus to the settling of the uterus into the pelvis, and with its enlarged dead weight producing undue pressure upon the nerves in the pelvis, causing a reflex action of the motor nerves.

Case II.—On the 25th of last November I was called to see Mrs. C., who was threatened with an abortion. Mrs. C. is thirty years old, and had always been regular as to time with her menses, though suffering slightly from dysmenorrhœa up to the 1st of October, since which they had not made their appearance. This being the first time she had ever missed, she was satisfied that she was pregnant, and, from the pains felt in her back and low down in front, and their paroxysmal character, believed she was about to miscarry. Her pulse was quick, skin hot, and she was evidently suffering a good deal of pain.

She was ordered to take a quarter of a grain of morphine every three hours, and cold acidulated drinks, and to keep her bed until she was free from pain. The next day she was nearly free from pain, but complained of feeling sore all over, as she expressed it. She was advised to keep her bed until she felt well, which was strictly followed four or five days, when she felt well enough to be up and mingle with her friends. I heard no more of her until the 13th of March, when I was called to see her, and found her again in pain, and some show evidently about to miscarry. Morphine was ordered, and rest, as before. In two hours she was free from pain, and felt so well that she took a short ride in a carriage, contrary to my advice, the same evening; yet she remained well until the evening of the 16th, when she was suddenly taken with severe labor-pains. I saw her at two o'clock on the morning of the 17th, and found her in active labor, with the os uteri so much dilated that I thought it useless to attempt to arrest the labor. Her pains continued, and were quite severe until four o'clock A.M., when she was delivered of twins, the placentas following soon after. The fœtuses appeared somewhat shrivelled, and did not look to be more than of six or seven weeks' growth, and were about the size I should have supposed them to have been at the time of the patient's first sickness, which was three months and twenty days before. The membranes having remained intact, there was no fœtor nor decomposition. No perceptible influence on the health of the patient was observed, excepting an occasional feeling of weakness, which lasted but a short time.

Dr. Ely, of Burlington township, related a case of retained placenta last September before the Bradford County Medical Society.

A woman miscarried, and the fœtus appeared to be of about four months' growth. The doctor was not present at the time; but, the placenta not coming away, he was called some hours after to remove it. On making an examination, he found the umbilical cord had been broken off within the uterus, and the os quite firmly contracted, and there was little or very slight hemorrhage. He concluded not to attempt to remove it, as there were no urgent symptoms. Supposing that the uterus would after a little time contract upon its contents and expel it, he directed the family to send for him if pains came on, and left. He heard no more for about five months, when he was called to the lady, who was in labor. In a short time he delivered her of an after-birth fresh in appearance as if immediately preceded by the birth of a child. The parts attached to the uterus were evidently not separated until the labor for its expulsion took place. No unusual fœtor was observed, nor had there been during the carrying the retained placenta, excepting a few days after the expulsion of the fœtus. The woman made a good recovery. Dr. Ely believed the expulsion of the placenta was at the full period of gestation; and had not the fœtus, from accidental or intentional causes, been previously expelled, it would have been born at that time.

Dr. G. F. Horton, of Terrytown, related a case at the same time where a placenta was retained several months without hemorrhage or much inconvenience to the patient, but could not say that it was carried to what would have been the natural period of gestation.

The writer is well aware that fœtuses are occasionally carried a few days, or perhaps two weeks, after they are dead, and that placentas are retained after abortions a number of days; but it is very unusual for them to be carried months, as in the above cases.

ATHENS, PA., April 5, 1873.

BLEEDING IN CERTAIN CASES OF PUERPERAL ECLAMPSIA.

BY RICHARD A. CLEEMANN, M.D.

IT is evident to the reader of current medical literature that bleeding, as a remedy in disease, is emerging in some degree from the disrepute into which it has of late years so deeply fallen. Especially is this the case where are concerned certain morbid conditions, of which the pathology is doubtful, but which have among their characteristics sudden and profound brain-disturbance. In such a category may be placed the puerperal state marked by the occurrence of convulsions; and three cases of this are recorded below as having a bearing upon this renewed advocacy of the lancet.

Case I.—I was called up on the night of May 24–25, 1868, to visit a primipara, said to be suffering terribly in her labor. The screams of the unfortunate woman—so loud as to have attracted two policemen under her window—were heard as we approached the house. Entering the bedroom, I found a young irregular practitioner of the neighborhood tugging at his forceps, applied over the child's head, which already occupied the cavity of the pelvis. The patient was a small, pale, black-eyed woman, of nervous temperament. She was attempting with great vigor to toss herself about, while uttering the loud cries already alluded to. It was said she had been seized with "spasms" before my arrival, though now I observed none of the consecutive symptoms. To shorten her intense suffering, I determined to use my own forceps at once, but had only time to adjust one of the blades, when, a strong contraction of the uterus taking place, the head of the child passed the vulva, the body and limbs soon following. After a certain time the first-called accoucheur attempted the delivery of the placenta—as I noticed too late—by traction on the cord, which ruptured just as the poor woman, with a loud cry, fell into a frightful convulsion. When the muscular contortions had ceased, the afterbirth was removed without difficulty by the hand introduced into the cavity of the uterus. Scarcely was this accomplished when, the patient starting wildly up, the blood poured out of the vagina like water from a hydrant. This was, however, the end of the trouble; the contraction of the uterus was soon assured, and the patient left quiet in bed. I did not see her again for several months, but learned that she recovered without a bad symptom.

The probable determining cause of the spasms in this case was uterine irritation, which ceased with the emptying of the womb,—quickly and easily accomplished at this period of the labor. The apprehension of cerebral effusion, aroused by the mental excitement, vanished with the opportune flooding instituted by nature.

Case II.—I was summoned in great haste at eleven A.M., January 21, 1871, to see Mrs. McT., multipara, with the explanation that she was suddenly attacked with convulsions, having been delivered the night previous, after an easy labor, of a child at full term. My patient proved to be a strong-looking woman, of nervo-sanguine temperament, of about twenty-five years of age. Three paroxysms of convulsions had occurred before my arrival, and she now lay comatose. Almost immediately another spasm of considerable violence, accompanied by frothing at the mouth, took place, and then another. The congested skin of the patient and the much-distended veins, that were like black tortuous cords twisted underneath, suggested dangerous vascular repletion. Her arm was tied up and a lancet plunged into a vein at the flexure of the elbow; the prick of the instrument caused a start from the patient, and a full stream of blood spurted forcibly from the aperture,—twenty ounces, judging by the eye, being soon abstracted. Placing a finger on the wound, I was watching the effects of the measure, when another convulsion took place: the finger was at once removed, but no blood flowed till the muscular disturbance had ceased, when again a full stream poured out; after about ten more ounces of blood had been allowed to escape, the patient became quite blanched in appearance, and the diminished force of the jet of blood showed a decided influence on the circulation. During the following one and a half hours the condition of the patient improved, and she seemed about to return to consciousness, when another convulsion supervened. She had had twenty grains of bromide of potassium in two doses meanwhile, and now a cloth saturated with chloroform was held over her nostrils till the muscular movements were discontinued. In a short time another spasm occurred, and before long another, and again another. A half fluidounce of turpentine in enema was now given. After about ten minutes had elapsed, the patient gave signs of great discomfort, moving her limbs and endeavoring to change her position: this uneasiness was relieved by an evacuation from the bowels, which was soon followed by another. After this there were no more convulsions, and the patient gradually regained consciousness. She experienced at first transient headache, and twitching of the hands was noticed. She was oblivious not only of the supervention of the eclampsia on her labor, but even of the birth of the child, which, as above stated, had taken place many hours before their occurrence. The next day I found my patient very cheerful, and in excellent condition; she progressed favorably in every way, and her breasts filled with milk in the usual time.

The appearance of her husband in a drunken condition immediately determined the convulsions of the last patient, a mental impression the disturbing effects of which might be expected to be transient, and demanding little treatment now that the labor was completed. The venesection practised, as stated above, was directed against the marked vascular repletion, which threatened dangerous congestions; and the quickly fortunate termination of the case shows that such a measure was not contraindicated by extreme hydræmia. In regard to the effects of the bleeding on the muscular disturbance, it may be plausibly said, according to the ingenious theory expounded by Prof. Joseph Carson (*Am. Jour. Med. Sci.*, April, 1871, and this journal, number for November 15, 1871), that the venesection was carried too far, and, by predisposing to syncope, was chiefly responsible for that second series of convulsions which occurred one and a half hours after the first was completed; but, as we see constantly the most violent eclampsia in children and epileptics, followed by no immediate bad effects, the criticism, in view of the greater danger of cerebral or pulmonary extravasation, is of little value. The happy sequence of the exhibition of the enema of turpentine, an arterial stimulant, lends its support to this view of the agency of syncope in the mechanism of convulsions; and in this connection it is worthy of remark that the failure of the blood to flow from the open vein during the muscular contortions, immediately succeeding the

first bleeding, is opposed to the generally received description of puerperal eclampsia, as regards the circulation, namely, that the "carotids beat inordinately," and that the pulse "increases in velocity as the intensity of the fit becomes greater." (Ramsbotham.)

Case III.—I was consulted January 27, 1872, by Mrs. H., a native of France, of sanguine temperament, aged about 38 years. She had been married twenty months, menstruated once afterwards, then had an abortion at three and a half months. The catamenia at the succeeding period were normal, but at the next nisus there was profuse hemorrhage, which recurred after three weeks. At the following three periods the menses were natural, the flow being scanty at their last appearance.

June 22, 1872.—It was calculated that she was now near the close of the seventh month of pregnancy. She came to see me about œdema of the feet, and I noticed that her hands and face also appeared puffy. Her calls to urinate were frequent, with a more copious discharge than usual, according to the patient's own estimate. Inquiry developed that there were also stiffness of the muscles, sensations of fulness in the head on stooping, and wakefulness; but these subjective symptoms occasioned but slight annoyance; the appetite was good, and the bowels were regular. Her urine, tested with heat and nitric acid, gave a small deposit of albumen, not sufficient, in an ordinary-sized test-tube that had been half filled with the urine, to occupy the convexity of the end. During the succeeding five days the condition of the patient did not improve, malaise and wakefulness occasioning more distress. After this time (on June 25) the patient complained of pain in the back of the neck and shoulders, and in the throat, also of burning sensations in right and left hypochondria; lying down brought on coughing, but the breathing was not embarrassed, and a clear note was yielded to percussion; the respiratory murmur was, however, of higher pitch than normal. The patient seemed to suffer intensely, and was very desponding, declaring incessantly that she should die. Remedies afforded but little relief, and at about 9 o'clock P.M. she fell into convulsions. Two paroxysms occurred before I reached her, within an hour, and at the expiration of that time another took place. An eminent obstetrician, who had been sent for in my absence, arrived shortly after myself, and gave me the benefit of his advice. Venesection was decided upon, and about twelve ounces of blood were taken from the arm. The operation was rather unsatisfactorily performed, owing to the thickness of the integument which obscured the position of the chief veins. The patient became subsequently less restless and more conscious, but after about five hours' interval (at 4.40 A.M., June 26) another violent convulsion took place, in which the patient's tongue, notwithstanding precautions were taken, was very much lacerated, the wound bleeding quite freely. She rallied once more after this, and was complaining from time to time that she was smothering ("*J'étouffe*"). Finally at 8.15 A.M. there was again muscular contortion, in which the patient's life ended, blood now issuing copiously from the nostrils.

In the treatment of this case, acetate of iron in the form of "Basham's mixture" was given when relief was first sought; afterwards jalap and bitartrate of potassa were also prescribed. On the day of the supervention of the convulsions, before their occurrence, three stools had been obtained, but, as they were feculent and it was desired to eliminate some of the water of the blood, elaterium was exhibited; the hydragogue was, however, rejected from the stomach, an evacuation from the bowels being afterwards procured by enema. Compound infusion of senna was then resorted to. For the pains an anodyne liniment was used. The bleeding practised after the convulsions occurred has already been alluded to; in addition, at this time, suppositories of belladonna and assafœtida were administered, and carbonate of potash and chloric ether given.

The immediate cause of death in this case seems to have been pressure upon, or laceration of, the medulla oblongata, the congestion of the upper portion of the spinal contents, betrayed by pain in the neck, shoulders, and sides, as in beginning cerebro-spinal meningitis, advancing till that great nerve-centre was fatally involved. Accepting this causation, it is thought that a large and rapid bleeding such as that practised in Case II. would have been of immense advantage. The surface of this patient did not present the same evidences of vascular fulness as that of the one in the case just alluded to; but this may have been owing to her thick white skin, so commonly found among the French, which would mask sanguineous plethora to the eye. Her subjective symptoms of wakefulness and fulness of the head on stooping pointed to that condition.

OULMONT ON TREATMENT OF MERCURIAL TREMORS AND PARALYSIS AGITANS BY HYOSCYAMINE.—Dr. Oulmont (*Gazette des Hôpitaux*, Jan. 11, 1873) considers that, although the results obtained by the treatment of neuralgia by hyoscyamine are satisfactory, they are neither more marked nor more rapid than those obtained by the use of opium or belladonna. In nervous diseases characterized by trembling, such as mercurial tremors, and paralysis agitans, marked benefit attends its employment, relief or cure being effected by it after all the other usual remedies, such as iodide of potassium, tonics, electricity, sulphurous baths, bromide of potassium, opium, etc., have failed. Four cases of tremors, treated with hyoscyamine, were cured, and two relieved; and two cases of paralysis agitans were relieved. In mercurial tremors he begins with a dose of two or three milligrammes of hyoscyamine daily, and gradually raises it, notwithstanding dryness of the mouth, etc., to twelve, or even seventeen, milligrammes daily. As the trembling ceases, the dose is gradually diminished. In paralysis agitans he gives six milligrammes daily, at first, and gradually raises the dose to ten.

LITTLE ON THE USE OF DIGITALIS IN THE FAILING HEART AND DELIRIUM OF ACUTE DISEASES.—Dr. Little (*Irish Hospital Gazette*, Jan. 15, 1873) recommends the use of digitalis in febrile cases in which stimulants are either not well borne or are contra-indicated, as, for example, in most cases where renal affection is present. He has given it in more than twenty cases, including six of typhus and one of rheumatic fever, the remainder being cases of enteric fever. He usually gives half-drachm doses of the tincture every three or four hours, rarely every hour, and discontinues the medicine when the pulse falls to eighty. Along with the digitalis he gives wine and brandy. In one case of rheumatic fever where stimulants could not be borne, he used tincture of digitalis alone. After several doses nausea occurred. The tincture was therefore discontinued, and a hypodermic injection, composed of one-eightieth of a grain of atropia, one-fortieth of a grain of digitalin, and one-fourth of a grain of morphia, was substituted. The patient eventually recovered.

PHILADELPHIA
MEDICAL TIMES.
A WEEKLY JOURNAL OF
MEDICAL AND SURGICAL SCIENCE.

The Philadelphia Medical Times is an independent journal, devoted to no ends or interests whatever but those common to all who cultivate the science of medicine. Its columns are open to all those who wish to express their views on any subject coming within its legitimate sphere.

We invite contributions, reports of cases, notes and queries, medical news, and whatever may tend to increase the value of our pages.

All communications must bear the name of the sender (whether the name is to be published or not), and should be addressed to Editor Philadelphia Medical Times, care of the Publishers.

PUBLISHED EVERY SATURDAY BY
J. B. LIPPINCOTT & CO.,
715 and 717 Market St., Philadelphia, and 25 Bond St., New York.

SATURDAY, APRIL 19, 1873.

EDITORIAL.

GRATUITOUS ADVICE.

THE letter signed "Struggling Practitioner," which appeared in our issue of April 5, contained some forcible truths, which the profession would do well to ponder. We have a few words to say at present in support and in extension of our correspondent's views.

He is perfectly right in stating that a great many persons become beneficiaries of charitable institutions who are well able to pay for medical advice. For the last twenty years we have observed this evil steadily growing, with the increase in the number of these establishments. As a matter of course, this is the case with the dispensaries from which the college clinics are fed; for all who come there must be attended to, so as to accumulate material from which to cull what is suitable for exhibition before a class. These, however, are not charities in any strict sense of the term; they are only such incidentally, and for a purpose.

But there is between institutions of the purely charitable class a certain rivalry, not as to the amount of actual good done to the deserving poor, but as to the number of cases attended, the number and brilliancy of operations performed, etc. An "interesting case" is too often admitted on the free list, to the exclusion of one of real suffering and destitution which presents no chance for trying some new method, or for great surgical exploits. This is all wrong. The generous offerings of the public should be applied to the relief of poverty and distress; and those patients who can pay for attendance should be required to do so.

Again, there are many private practitioners who give their services to those who are well able to pay, and who would do so if they were rightly dealt with. We allude to servant-girls, mechanics, and others in the lower ranks of life. These people indulge in many luxuries of dress and amusement, but expect to have what medical attendance they need either gratis or for a nominal sum.

Another point we touch upon with some apprehension lest we should be misunderstood. The relation between physicians and the clergy has never been clearly established. There is a generally prevalent idea that medical services are to be rendered gratuitously, as of right, to members of the latter profession. And yet it is among clergymen that quacks and quack medicines have ever found ready and willing patrons and endorsers. In large cities, at least, the pecuniary position of the clergy as a class is more comfortable than that of physicians as a class. And we cannot but think that they ought to decline to lie under obligation to a body of men so largely drawn upon for charity as medical men are.

All these things would be, in our humble opinion, rectified by a little common sense, thoroughly carried out. Let every physician, whether in a public capacity or in his private practice, look upon his services as having a definite marketable value. Let him consider that those who seek his services ought, if they can, to pay for them, and if they cannot, to receive them as charity. He may, if he sees proper, decline to charge his clergyman, or any other friend, for services rendered; but no one can claim medical advice from him, any more than he himself can demand tea or coffee from a grocer, or meat from a butcher, without offering a due equivalent.

A DIFFERENT THING.

OUR esteemed cotemporary, the *Boston Medical and Surgical Journal*, in its issue of April 10, has the following item:

"NOT AMERICAN THIS TIME!—'It has just come to light,' says the *Lancet* of March 22, 1873, 'that during the last few years a large trade has been going on in forged diplomas purporting to be from the *German* University of Marburg, no less than forty persons in this country having purchased the worthless documents.'"

This, we submit, is quite a different thing from the "American" business of diploma-selling, which

we and others have sought to destroy. Its effects, indeed, are the same, in that unqualified persons are furnished with the means of imposing on the public. But it is a mere matter of forgery: the genuine diplomas of the University of Marburg, a highly respectable institution, are imitated.

Obviously, in this case the makers and sellers of the spurious diplomas on the one hand, and the buyers and users on the other, are the guilty parties. The injury falls on the University, whose genuine certificates must depreciate in value, and on the public, who are led by the false papers to repose confidence in their holders.

Far otherwise was it in the case of the bogus colleges in this State. Here the authority of the legislature was invoked to establish and to sanction institutions which, for a mere pecuniary consideration, issued diplomas which, though genuine, were valueless. Every medical school in Pennsylvania, and in fact in the United States, has suffered in standing, every "American diploma" has become a thing of uncertainty, open to more or less suspicion; and yet the evil has been far more difficult to deal with, and has not yet been wholly reached.

SOME SANITARY FACTS.

WE would call attention to a few curious facts, which are perhaps susceptible of some explanation which has not, as yet, occurred to us, in regard to the mortality of this city.

Notwithstanding the severity of the winter, the death-rate has been uniformly and markedly lower, week by week, than during the corresponding months of 1871–2; and this in a degree, it seems to us, much greater than can be accounted for by the variolous epidemic of the winter before last.

Again, while the interments for the week ending April 5 were 332, the number fell to 256 for the ensuing seven days. The deaths from consumption, in the latter period, were but 28 to 63 in the former; a diminution of over 50 per cent. The deaths from other diseases of the respiratory organs fell from 48 to 33; a diminution of nearly 32 per cent.

Another point which strikes us as singular, although it may be that it is the rule in other cities also, is the large number of deaths ascribed to diseases of the brain and nervous system. The average for thirty consecutive weeks was 46; the smallest number having been for the week ending October 19, 1872,—30, and the largest for the week ending March 15, 1873,—71.

These facts have happened to attract our notice casually, and are perhaps by no means the most remarkable of those which a closer study of our vital statistics would develop. We should be very glad to think that the whole subject was under careful investigation here, and that the result might be of benefit to the public welfare.

CORRECTION.

IN the report of Prof. Gross's clinical lecture on lithotomy (page 420 of this volume) the following corrections made in the proof arrived too late to be made in the published report: When sounding the patient, instead of "perfectly nude," read "the lower part of the body should be nude;" and, for "the bladder should be full of urine," read "it should contain three or four ounces of fluid."

PROCEEDINGS OF SOCIETIES.

MEDICAL SOCIETY OF THE COUNTY OF ALBANY, NEW YORK.

SEMI-MONTHLY MEETING, March 26, 1873.

Reported by JAMES S. BAILEY, M.D.

DR. ALBERT VAN DERVEER, PRESIDENT, in the chair.

DR. CHARLES S. HOYT, Secretary of the Board of Public Charities of the State of New York, spoke on the subject of the *care of the insane*, and remarked that the census report had not been reliable as to the number of insane people in the country, which had been shown by the census of insane taken in two or three instances by boards of public charities.

It was found in 1871 by Dr. Hoyt that the total number of insane in this State was 6775. Of these, 1582 were in the custody of friends, 1093 in State institutions, 312 in private institutions, 3552 in city and county poor-houses, and 161 in institutions in other States. In Albany County the number of insane is 223, or 1 to 551 inhabitants,—a larger proportion than any other county, except Oneida, New York, and Kings. Of these, 66 are in the county poor-house and 105 in State institutions, the rest being scattered in private institutions, taken to other States, or retained in the custody of friends.

It has been a matter of interest to find how many have become insane during the year. There have been 761 recoveries and 502 deaths among the insane of the State. By deducting from the total number of insane it is found that 1678 new cases of insanity have occurred, or 1 to every 2612 of population.

The circumstances under which the insane have recovered are largely in favor of hospital treatment. Of 761 recoveries only 43 were of those under the care of friends. It was urged on physicians to send insane patients as soon as possible to the asylum, and also to try and remove the prejudice existing against these institutions, which is largely due to lack of information.

The charges that have been made from time to time are for the most part unfounded. Those against Bloomingdale are shown to have been entirely malicious. The

hope of recovery diminishes as time advances,—a large proportion of recoveries being within a year.

It was urged that this county could best take care of its insane by building an asylum of its own, and that this would be more economical. It costs from $20 to $35 to transport patients to distant institutions, which sum would pay the interest on the cost of building.

There are now 66 insane in the county poor-house because of lack of accommodations elsewhere; and they ought not to be deprived of advantages which the others enjoy. Epileptics, too, are a dangerous class to have at large, and for them there is no public provision. He thought that the cost of maintaining 250 patients would be about three dollars a week, in an institution having a large vegetable farm attached. This is what is paid by the county for patients at the Willard Asylum. Mr. Hoxsie—overseer of the poor of the County of Albany—said that we have 102 patients in the Willard Asylum, and 50 or 60 whom he would be glad to send there if there was room. A number of supposed hopelessly insane sent to Willard Asylum, when first established, had been returned cured. He spoke highly of the care given there. The supervisors of this county decided not to build an asylum, on account of the expense, but they had appropriated $35,000 for this year's care, the largest ever set apart. We shall never have a less number; and it would not take many sums of this amount to erect a home asylum. It might, too, be made remunerative by taking from other counties. The accommodations in the State asylums are entirely insufficient, as shown by the fact that they are crowded, and many patients are now in other States or in the custody of friends.

Dr. JAMES S. BAILEY reported a case of *poisoning by aniline*. A workman in the employ of the Aniline Company undertook, contrary to the advice of the foreman, to open an iron cask containing aniline oil and arsenious acid. The gas formed by the intense summer heat was liberated, and, being inhaled, caused asphyxia. He was carried home in an insensible condition, and remained so for fourteen hours, and he was prostrated for two weeks by a bronchial affection caused by the irritation which the gas produced in the air-passages.

In 1868, Professor Wirtz, of Paris, while demonstrating the properties of aniline as a coloring-matter before his class, applied heat, and on inhaling the fumes fell senseless, and immediately expired.

Dr. JAMES S. BAILEY also reported the history and post-mortem appearances of a case of *rupture of the œsophagus* occurring near the cardiac orifice of the stomach, causing collapse and death in twenty-four hours from its occurrence. In this case the accident was probably due to a violent fit of vomiting. Substances swallowed passed into the cavity of the chest through the fissure.

The lesion in a sound œsophagus is a rare one. Von Oppolzer reports having seen but one case.

Dr. ALBERT VAN DERVEER reported the following interesting case of *pyelitis*.

Mr. C., æt. 45; sailor; exposed to great hardships from boyhood. Complained of nausea and vomiting, and pain in lumbar region; difficulty in urinating, and a frequent desire to do so night and day, but passing but little at a time. Respiration was frequent and labored.

Examination of urine revealed one-third albumen, with an abundance of pus-corpuscles.

Post-mortem made five hours after death, in order to enable the friends to transport the body a distance for burial. Body much emaciated. There were strong pleuritic adhesions extending over the entire surface of both lungs, evidently of long standing. Lung-tissue healthy. Heart normal. Liver somewhat enlarged, pale, and fatty. When the peritoneal coat is torn off, portions of the liver follow, giving it a granular look; the tissue is easily torn. Spleen and pancreas, stomach and intestines, normal.

Kidneys.—Right one firmly held in lumbar region by adhesive inflammation of surrounding cellular tissue; with difficulty removed; appears large, full, and distinctly fluctuating. Ureters very much enlarged and thickened; upon section a pus-like fluid freely escapes. The kidney measures six inches in length, four inches in width, and three inches in thickness, and weighs twelve ounces. No fat or tissues left attached to capsule; capsule firmly adherent to the small portion left of the cortical substance. The tubular part seemed completely occupied by from twelve to fifteen distinct abscesses, and these seem to have destroyed particularly the pyramids, occupying their places. There is a well-defined wall existing between most of the abscesses, all of which have their exit towards the pelvis of the kidney. Not a well-defined pyramid is left, and but a small portion of the cortical substance remains. Left kidney easily removed; large and of a pale color; two or three small cysts on its surface; weight seven ounces, length six and a quarter inches, width three and a half inches, thickness two inches. Capsule easily removed; cortical surface appearing coarse and granular. Upon laying open the organ, the pyramids were well defined, but appear coarse and congested; the cortical substance also appears congested.

Microscopical appearances of the left kidney, by Dr. Blatner.—The consistence of kidney is soft, and paler in color than normal. The contrast between the cortical and medullary substance is striking. There is a diffuse cellular hyperplasia of the connective tissue near the convoluted urinary tubuli and the Malpighian corpuscles. There are also numberless young cells and some oil-globules perceptible. The Malpighian corpuscles have also become shrivelled.

REVIEWS AND BOOK NOTICES.

DISEASES OF THE URINARY ORGANS: including Stricture of the Urethra, Affections of the Prostate, and Stone in the Bladder. By JOHN W. S. GOULEY, M.D., etc., etc. With One Hundred and Three Wood Engravings. 8vo, pp. 368. New York, William Wood & Company, 1873.

The title of this work is too comprehensive, since it would lead any one to suppose that the diseases of the kidneys are discussed in it, whereas it embraces but a limited number of the vesical and urethral troubles of the male sex only. And it is devoted almost exclusively to the surgical treatment of this class of disorders. A better name would have been "Vesical and Urethral Surgery."

Dr. Gouley has written clearly and well, from a large practical experience; and we have little to say except in commendation of his work. He begins with a tolerably full résumé of facts in regard to stricture of the urethra, its causes, symptoms, and sequelæ. For the diagnosis of this troublesome affection he justly prefers the bulbous or olivary bougie.

We are somewhat surprised at the way in which the endoscope is mentioned, since the reader is not informed as to the extent to which it is used or the value of its revelations. Unless we are much mistaken, this instrument has altogether disappointed the expectations of its friends, and has been laid aside even by those who a few years ago were warmest in its praise.

Dr. Gouley is well known as one of the advocates of "tunnelled" instruments for stricture; and he gives very full directions for this plan, which we believe to have great merits. The idea is to employ a fine whale-

bone guide, which, being carried past the seat of constriction, may serve to lead a metallic instrument, grooved or tunnelled so as to slide along into the bladder. Whether for dilatation, divulsion, external or internal urethrotomy, this method has, in our author's hands, been found practically valuable. All the disorders causing difficulty in urination are quite fully discussed, with the various modes of treating them.

The concluding portion of the book, on stone in the bladder, occupies three chapters. Lithotripsy, lithotomy, and perineal lithotrity after the method of Dolbeau, are well described and fully illustrated. Our author gives a very decided opinion, backed by a larger array of statistics than we had supposed available, in favor of median lithotomy.

We are very glad to welcome this able contribution to American surgical literature. It is not so exhaustive as the treatises of Sir Henry Thompson on Stricture and on Lithotrity and Lithotomy, nor does it pretend to be; but it is a very clearly-written and practical guide, and will be found useful by a large class of readers. Its mechanical execution is very creditable, and it contains remarkably few typographical errors.

THE SCIENCE AND ART OF SURGERY: being a Treatise on Surgical Injuries, Diseases, and Operations. By JOHN ERIC ERICHSEN, Senior Surgeon to University College Hospital, etc. A New Edition, enlarged and carefully revised by the Author. Illustrated by upwards of Seven Hundred Engravings on Wood. 2 vols. 8vo, pp. 781–918. Philadelphia, Henry C. Lea, 1873.

Mr. Erichsen's work, which has now attained a size which necessitates two volumes even for the American edition,—and they are much pleasanter to handle than their enormous single predecessor,—is unmistakably a London book, by a London author, and suited, we may say, to London readers. That it is valuable would be evident merely from the demand which warrants a sixth re-issue of it, despite its many younger and fresher rivals for the favor of the profession. And yet it has never been a very satisfactory book to us, from the diffuseness of its style, and the scanty references given, but above all for a certain lack of spirit.

The author takes up his subjects, discusses them, and lays them down, one after another, with propriety and correctness, but without enthusiasm. He seems to place a good deal of stress upon matters which are not, after all, the essence of surgery,—rather preferring complicated forms of apparatus and procedures which require special appliances. Hence his book would fail to meet the needs of some of our brethren who are out of the way of instrument-makers, and must achieve their triumphs—and noble triumphs they often are—by working out principles with rough and ready tools.

We note that in the present edition the modern researches in pathology, by Cohnheim and others, are mentioned; and the valuable contribution of Dr. Bigelow to the surgery of the hip-joint receives due weight. Lister's antiseptic method is described with approbation. Chloroform seems to be the anæsthetic decidedly preferred, notwithstanding its risks.

Mr. Erichsen does not appear to have adopted the modern views in regard to syphilis. His chapter on venereal diseases is, indeed, the least satisfactory in the book. He thinks that some mercurial treatment is almost always required,—an opinion which we hardly think has many adherents in this country at the present day.

The illustrations which have been added in this edition are very inferior, not only artistically, but as aids to the understanding of the text. For example, the cut on page 488 of vol. ii., of a laryngoscopic examination, is incorrect in almost every particular.

We have found much fault, but honestly, with this work. We do not think it can be accepted as a cyclopedia of surgery. And yet it is a book which every surgeon who has a library will do well to buy and to consult, as containing, in spite of its defects, the results of the experience in hospital and private practice of one of the leading men of the day.

TEXT-BOOK OF PHYSIOLOGY: General, Special, and Practical. By JOHN HUGHES BENNETT, M.D., F.R.S.E., Professor of the Institutes of Medicine or Physiology, and Senior Professor of Clinical Medicine, in the University of Edinburgh, etc., etc. With twenty-one Photo-lithographic Plates. Small 8vo, pp. 606. Philadelphia, J. B. Lippincott & Co., 1873.

This may fairly be placed in the rank of "great little books." It is written in a singularly clear and concise style, with no waste of words, and yet is pleasantly readable. A somewhat careful examination of it has satisfied us that it is fully up to the present state of science, and well adapted to the wants of the student, as well as of the more advanced reader.

The work is divided into three parts. Part I., on General Physiology, embraces the Chemistry of the Tissues, General Histology, the Physical and Vital Properties of the Tissues, and Life or Vitality. In Part II., on Special Physiology, are treated Nutrition, Innervation, Reproduction, and Death. Part III., on Practical Physiology, is devoted to Practical Chemical Physiology, Practical Histological Physiology, and Practical Experimental Physiology.

The illustrations, which are on a somewhat small scale, are very good. They are massed together at the end of the volume, with explanatory pages opposite to each plate. This arrangement, as well as the photo-lithographic method, was adopted for the sake of economy, and, we think, wisely.

We regret to note a good many typographical errors; but none are of serious moment. We regret also that so few Americans have given themselves to researches in this branch of science, so that hardly a single countryman of ours is to be found among the many authorities quoted.

MYRINGECTOMY, ETC. By J. S. PROUT, M.D., of Brooklyn, N.Y.

This is an account of a case of chronic catarrh of the middle ear, in a lady, thirty-three years old, relieved by myringectomy, after all other remedial measures had failed. The hearing-power for the watch and voice steadily decreased, although the catarrhal condition of the throat and Eustachian tubes was relieved. At last, an adhesion between the membrana tympani and the promontory was discovered, which we are left to infer occurred during the treatment. Its presence was indubitably settled by the use of Siegle's pneumatic aural speculum. The operation was performed upon the right ear, but produced no improvement in the hearing-power for the watch,—normally audible thirty-six inches,—although immediately after the operation the *voice* in conversation was heard very much better. But the voice is such a treacherous test!

The author explains the improvement in hearing in the following words:

"The membrane of the round window now receives the sound-waves and transmits them to the auditory nerve in the cochlea.

"Some of the improvement may be perhaps attributed to an improved co-ordination in the vibrating power. The two membranes may have been unequally attuned, and, therefore, a condition somewhat similar to diplopia may have existed. There was no double hearing."

One year after the operation the opening in the membrana tympani had not closed,—a fact which the author does not attempt to explain.

It is to this permanent opening we may ascribe the improvement in hearing,—in this case as well as in others where the opening has been maintained.

C. H. B.

THE CREDIT GUIDE. Philadelphia. Vol. II., No. 1, 1873, pp. 144.

This is a book the merits of which can scarcely be recognized by casual examination. We have reason to know that the compilers have endeavored to make it as full and as correct as possible; and it would be well for the practitioners of the city to give a fair trial to this attempt to furnish a defence against those who are willing to evade payment of their bills. Copies may be obtained by addressing the agent, Mr. R. A. Schwab, No. 711 North Twentieth Street.

GLEANINGS FROM OUR EXCHANGES.

PODOLINSKI ON THE EXPULSION OF CARBONIC OXIDE AND NITRIC OXIDE FROM THE BLOOD.—In opposition to commonly received opinions, Donders recently stated that carbonic oxide could be expelled from its hæmoglobin compound by other gases; and Zuntz has separated it by means of the vacuum. S. Podolinski (Pflüger's *Archiv*, vol. vi., part 11), under the direction of Hermann, compares the comparative displacing power of hydrogen and oxygen on the carbonic oxide compound, and also on the nitric oxide compound with hæmoglobin. He finds, on operating on small quantities of carbonic oxide blood with hydrogen, in a manner which allows complete mixture of the two, that half an hour is sufficient to expel all the carbonic oxide from blood saturated with this gas. Atmospheric air acts still more rapidly. In regard to nitric oxide in blood, hydrogen alone was used to expel the gas, in order to avoid formation of nitric peroxide. In this case, also, the compound was completely broken up, and nitric oxide expelled, but longer time was necessary. Hence Donders's discovery that carbonic oxide can be expelled by indifferent gases is extended to nitric oxide; and therefore the relation of hæmoglobin to the gases combining with it is, that oxygen, carbonic oxide, and nitric oxide can be expelled by indifferent gases, the degree of difficulty increasing in the same order. Each of these gases can be expelled by the one immediately following it with more ease than by an indifferent gas, and apparently, also, each is more easily evolved by the action of the one immediately preceding.

EMETICS AND NAUSEANTS.—*Le Mouvement Médicale* quotes from the *Bulletin de Thérapeutique* of March 15 the following remarks, from an article, by M. D'Ornellas, on the physiology of vomiting:

"The distinction between emetics pure and nauseant emetics is not altogether natural, since characteristic examples of each variety are rare, and the two effects are generally found combined in the same substance. M. Gubler thinks that an emetic is energetic in proportion to its nauseousness, acting not only on the stomach, but also on the buccal, nasal, and pharyngeal cavities. There is no doubt that the direct action of some articles is due to a different substance from that which produces the indirect. Thus the nauseant action of ipecacuanha is due to a principle having odor, and separable by ether (Magendie and Pelletier), the emetic influence to emetia, separable by water, and especially by alcohol (Magendie). These substances act as follows: The emetia acts always directly upon the gastric mucous membrane, upon its sensitive nerves, while, on the other hand, the nauseant principle acts upon the nerves of special sense, of the tongue, pharynx, and nose, and causes vomiting as soon as it is swallowed, or even before, independently of any local gastric action, or of elimination."

CONGENITAL ABSENCE OF A PORTION OF THE PECTORALIS MAJOR MUSCLE, AND THE WHOLE OF THE PECTORALIS MINOR ON THE LEFT SIDE (*Lancet*, March 15).—Dr. Burney Yeo reported this case at a recent meeting of the Clinical Society of London, and exhibited the patient, a boy aged 14. The case had come under his notice as an out-patient at the Brompton Hospital, the great apparent depression and flattening of the right side of the chest having induced the boy's friends to believe that he was suffering from serious intra-thoracic disease. The deformity produced by the absence of these muscles was very considerable, and was increased by depression and imperfect development of the right side of the sternum and the adjacent ribs and cartilages. No ensiform appendage could be felt. The clavicular portion of the pectoralis major was considerably hypertrophied, and the posterior fold of the axilla, containing the fibres of the latissimus dorsi, felt much thicker than that on the opposite side. There was a remarkable difference in the radial pulses on the two sides,—that on the right side being exceedingly small and weak, seeming to indicate some irregular distribution of the vessels on the same side as the muscular abnormality. The boy in all other respects was well developed, though small. He had never complained of any weakness of the right arm, and he was not left-handed. Dr. Yeo believed that a similar muscular defect had been rarely observed during life. He had appealed to Professors Flower, Humphry, and John Wood, and they had all assured him that they had heard of no like observations in the living subject. Several anatomists had recorded partial absence of the pectoral muscles observed on dissection, and within the last few days Mr. Taylor, of Guildford, had informed Dr. Yeo that he had now under his observation a volunteer in the Second Surrey Militia, with complete absence of the left pectoralis major. Cyrtometric tracings, showing the difference in the dimensions of the two sides of the chest, were handed round.

Mr. Nunn showed a sketch of a similar case, in which also some deficiency in the latissimus dorsi existed, and remarked that another case of a similar kind had come under his notice, having been treated previously at a special hospital for deformities, the authorities at which had enjoined the use of a back-board.

Another case of this anomaly is put on record by a correspondent of the *Lancet* for March 29, as follows:

"Four years ago, in India, while at the house of a cavalry officer, a quondam medical student, he took the opportunity of exhibiting this freak of nature. He was a man of powerful build, and excelled at all athletic sports. There seemed a great triangular depression on the right side of the thorax; but it was at once seen that this was not due to any falling in of the ribs. The well-developed left breast, and the large rounded right shoulder, rendered the absence of the muscle extremely well marked, especially at the acromial end of the clavicle, where there was a very well-defined hollow."

THE TRANSFUSION OF BLOOD.—The Transfusion Committee, appointed by the Obstetrical Society of London, has adopted the following programme of its aims and objects:

1. To collect evidence from gentlemen who have had experience in cases of transfusion.

2. To obtain the particulars of all recorded cases (performed on the human subject), with the view of finding out, as far as possible, to what extent the so-called successful cases were due to transfusion.

3. To examine the various kinds of instruments used in both the mediate and immediate forms of the operation.

4. If considered necessary, to institute further experiments for the purpose of determining how far transfusion may be relied upon as a means of saving life, and also the best mode of performing the operation.

SIRÉDEY AND CORDIER ON THE TREATMENT OF ANASARCA, ASCITES, AND OBSTINATE PLEURITIC EFFUSIONS BY MILK.—MM. Sirédey and Cordier (*Journal de Médecine et de Chirurgie Pratiques*) have used this old and rather favorite remedy against dropsies in a way which they consider renders it less troublesome and repugnant than the "milk-cure" is otherwise apt to be. At the same time that Sirédey prescribes two pints of milk a day to his patients, he allows other kinds of food and drink. Cordier, in his thesis, cites cases of albuminuric dropsy in which the diuresis was rapid and considerable, and the dropsy disappeared under this treatment. The diet is otherwise moderate, including meat and a little wine. He does not give more than two to two and a half pints of milk, at convenient intervals, in the day. He prefers asses' milk.

ISNARD ON THE TREATMENT OF CONSTIPATION BY ARSENIC.—Dr. Isnard (*Marseille Médical*, 1872) states that many other physicians besides himself have observed that arsenic excites the appetite and improves the digestion, and facilitates the action of the bowels, but he is not aware that it has been methodically applied for the relief of constipation. Besides (1) improving the appetite, it (2) excites the muscular action of the intestines, and (3) it augments the secretions of the alimentary mucous membrane. It is particularly useful in the constipation of debilitated and anæmic females, sedentary persons, and old people. He administers arsenious acid in the dose of six to ten milligrammes, twice or thrice a day, with food. Sometimes smaller doses suffice. It may be used steadily for some time.

DIGITALIS AN ANAPHRODISIAC.—M. Gourvat, in the course of a paper published in the *Gazette Médicale de Paris*, on the action of digitalis, says, "When digitalis or digitalin is administered for some time to a man in full possession of sexual powers, these become gradually weakened, the propensities disappear, formation of the liquor seminis diminishes, and may at last cease altogether. The anaphrodisiac properties of the drug are the secret of its good effect in spermatorrhœa."

MISCELLANY.

THE BRITISH DEATH-RATE.—The London *Echo* quotes as follows from official statements: "Taking an average for the thirty-three years, 1838–70, we find that the number of deaths in England to every 1000 of the population is 22.4. Of course, the death-rate varies with each year, the figures ranging from 20.5 in 1856 to 25.: in 1849, when the cholera visited us with fearful severity, destroying no fewer than 53,273 lives,—13,161 in London alone, and in little more than three months. The twelve most fatal causes are as follow, the figures attached showing the number of deaths due to each disease in 1870: phthisis (consumption), 54,231; bronchitis, 46,699; scarlet fever, 32,543; atrophy and debility, 30,530; old age, 28,889; convulsions, 26,548; diarrhœa, 25,311; heart-disease, 23,957; pneumonia, 23,729; hooping-cough, 11,901; paralysis, 11,651; and apoplexy, 11,598.

"From alcoholic poisoning 645 deaths resulted, 337 being cases of delirium tremens. Heart-disease seems to be on the increase, which is attributed by eminent physicians to the greater wear and tear of business and the increased mental activity of the age. To external causes 16,593 deaths in the year were directly referred. By railway-accidents 930 persons lost their lives; by accidents in coal-mines, 1000; 'mechanical injuries' killed 5730,—4136 arising out of 'horse-conveyance,' and 454 from the fall of heavy substances. Sunstroke killed 112 persons, and lightning 19. Of deaths by suffocation, 444 young children were smothered by bedclothes, and 171 were 'overlaid.' The proportion of suicides to every million of the population is about 70; the deaths by hanging, the knife, and drowning, being most numerous."

HERE is a nut for honest homœopathists to crack. The *Homœopathic Review* says,—

"The obligations of the homœopathic practitioner to his patients to relieve pain and to stave off death are higher than his duty to practise homœopathy. If he cannot, whether from the incompleteness of science, or from his own imperfect acquaintance with it, prescribe homœopathically, he must use such measures as, within his knowledge, are most likely to achieve the end he has in view. He is the most successful physician who, within the limits where a homœopathically acting medicine can effect good, can relieve and cure, *most seldom* falls back upon an allopathic palliative."

The plain English of this is, that the dogma "*similia similibus curantur*," with the psoric theory of chronic disease, the attenuations, potencies, triturations, and dilutions of medicines, will not hold water, and must be abandoned when matters begin to look serious.

INTERNATIONAL MEDICAL CONGRESS IN VIENNA.—The third international medical congress will be held in Vienna during the week from September 24 to October 1, under the patronage of the Archduke Rainer. The following are the subjects proposed by the Executive Committee for discussion: 1. Vaccination; 2. Quarantine in its Relation to Cholera; 3. Prostitution; 4. The Sanitation of Towns; 5. Proposals for an International Pharmacopœia; 6. Proposals for making Medical Education as uniform as possible in all countries, and for establishing reciprocal right of practice. The German language will be used in introducing the subjects; but the subsequent discussions may be in French, English, or Italian, as well as in German.

RICHARD PARTRIDGE, F.R.S., a well-known surgeon and anatomist of London, Professor of Anatomy for twenty years to the Royal Academy of Arts, and for thirty-six years to King's College Hospital, died recently, aged 68. He was one of the surgeons summoned to attend Garibaldi after the battle of Aspromonte, but failed to find the ball which Nélaton afterwards detected with his porcelain-tipped probe.

MEDICAL ADVERTISING.—The Council of the Royal College of Surgeons has, upon the motion of Mr. Charles Hawkins, passed the following resolution:

"That the practice of frequently advertising medical works in the non-medical press is, in the opinion of the Council of the Royal College of Surgeons of England, not conducive to the honor and dignity of the medical profession."

An editor says, "We have lately heard of the diagnosis of a new disease discovered by our associate editor, Dr. S., not long since. A lady of remarkable conversational powers approached our medical friend with, 'Dr. S., I have a very sore tongue.' 'Let me look at it,' says the doctor. The unruly member was duly protruded. 'It is sunburnt, madam, sunburnt,' remarked the doctor, who suddenly recollected that his professional services were wanted in another direction."

The out-door physicians of the Guardians of the Poor have formed themselves into an association, with the following gentlemen as officers:

President, M. B. Musser, M.D.
Vice-President, E. J. Nolan, M.D.
Secretary, A. C. W. Beecher, M.D.
Treasurer, Frank B. Hazel, M.D.

Asylum Amenities.—"Injuries inflicted upon patients in insane hospitals are generally the result of an inadequate number of servants in immediate attendance on the inmates. With a sufficient number of attendants always present, the most perverse patient, perceiving non-compliance utterly useless, will quietly submit." Such was Conolly's advice thirty years ago.

According to the *Lancet*, the Registrar-General states, in his annual summary of the weekly returns, that London has now upwards of four million souls, and had in the middle of 1872, within the limits of the health returns, 3,311,298 inhabitants. The estimated increase of population was 44,839. The average mortality of the year was 21 per 1000.

American Medical Association.—The undersigned proposes to charter a *palace car* for the trip to St. Louis. Cost to each passenger, six dollars. Leave Philadelphia May 2, noon; Baltimore, 4.15 P.M. All who desire to avail themselves of this opportunity should address

W. B. Atkinson,
1400 Pine Street.

At a recent meeting of the Société de Biologie, in Paris, M. Cl. Bernard announced that the daughter of the late M. Rayer had sent a donation of six hundred francs, in token of the interest taken by her father in the society. The money would be applied to the publication of the proceedings.

Philadelphia County Medical Society.—Dr. J. Solis Cohen will deliver a lecture at the Conversational Meeting, April 23, at 8 P.M., on Acoustic Phenomena, Normal and Pathological, illustrated by physical and physiological experiments.

The treasurer of the Aberdeen Infirmary, in a letter to *The Times*, asserts that "Hospital Sunday" has been an institution in that city since 1784.

Mortality of Philadelphia.—The interments reported at the Health Office for the week ending April 12, 1873, were 256; 138 adults, and 118 minors. 10 were of bodies brought from the country; making the mortality of the city 246. Among the assigned causes of death were:

Consumption of the Lungs	28
Other Diseases of the Respiratory Organs	33
Diseases of the Circulatory Apparatus	11
Diseases of the Brain and Nervous System	54
Diseases of the Digestive Apparatus	24
Zymotic Diseases	25
Typhoid Fever	3
Diseases of the Urinary Organs	5
Casualties	8
Cancer	9
Debility (including "Inanition" and "Marasmus")	24
Still-born	13
Old Age	7

(The interments reported for the week ending April 13, 1872, were 439.)

The meteorological record kept at the Pennsylvania Hospital was as follows:

		THERMOMETER.		BAROMETER. (2 P.M.)
		Max.	Min.	
April	6	60.0°	42.0°	30.15 in. (Thunder-storm.)
"	7	61.0	44.5	30.09 in.
"	8	62.0	47.0	29.95 in.
"	9	57.0	51.5	30.02 in. (Thunder-storm.)
"	10	59.0	45.5	30.28 in.
"	11	69.5	47.0	30.20 in.
"	12	43.5	36.5	29.83 in. (Rain and Snow.)

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY, FROM APRIL 8, 1873, TO APRIL 14, 1873, INCLUSIVE.

White, Robert H., Assistant-Surgeon.—Relieved from duty in the Department of the South, and to report to the Commanding General Department of the Lakes for assignment to duty. S. O. 74, A. G. O., April 9, 1873.

Kimball, J. P., Assistant-Surgeon.—To proceed to Yankton, D.T., and report to the Commanding Officer Battalion 7th Cavalry, for duty upon the Yellowstone Expedition. S. O. 64, Department of Dakota, April 2, 1873.

Carson, Joseph K., Assistant-Surgeon.—To report in person to the Commanding General Department of the South, for assignment to duty. S. O. 74, c. s., A. G. O.

Matthews, W., Assistant-Surgeon.—Relieved from duty at Willett's Point, N. Y. H., and to report in person to the Commanding General, Department of the East, for assignment to duty. S. O. 76, A. G. O., April 12, 1873.

Mc Millin, Thomas, Assistant-Surgeon.—Died, April 6, 1873, in camp at Headquarters Modoc Expedition.

BOOKS AND PAMPHLETS RECEIVED.

Principes de Biologie appliqués à la Médecine. Par le Docteur Ch. Girard. Small 8vo, pp. 108. Paris, J. B. Baillieu et Fils, 1872. (Principles of Biology applied to Medicine. By Dr. Ch. Girard.)

Ophthalmic Contributions. By George Strawbridge, M.D., Lecturer on Diseases of the Eye and Ear in the University of Pennsylvania, etc. 8vo, pp. 26. Illustrated. Philadelphia, Lindsay & Blakiston, 1873.

Catalogue of the University of Pennsylvania, 1872–3.

Transactions of the Third Annual Session of the Medical Society of Virginia, 1872. 8vo, pp. 178.